MEMBER ISSUE ESCALATION

	Meridian	NH Healthy Families	Well Sense
Member needs to resolve an issue.	Step 1: Member contacts Member Services by telephone, email, or Member Portal to discuss the issue. Step 2: Member Services works within Meridian Departments to resolve issue. Step 3: If the Member is dissatisfied with resolution, Member is given opportunity to file a grievance or appeal.	Step 1: Member contacts Member Services to discuss the issue via phone, email, or Member Portal. Step 2: If Member is dissatisfied with resolution, Member referred to Member Services Supervisor. Step 3: If Members is dissatisfied, member is given opportunity to file Grievance or Appeal.	Step 1: Member contacts Member Services Interactive Voice System (English or Spanish); may choose a Well Sense Customer Service Rep (CSR) or a vendor CSR. Step 2: CSR attempts to resolve issue at contact. If not, elevates the issue to senior team members with call back to member. Step 3: If no resolution, the member and/or authorized rep (AR) is offered formal grievance/ appeal rights (If accepted, member/AR may submit in writing or on phone with CSR).
Member wants to file a Grievance. **Grievance** - ability of Member to express dissatisfaction with any aspect of his/her care such as quality of care or service and respect of member rights.	Step 1: Member Services Grievance Specialist receives grievance & submits to appropriate Meridian Department for resolution. Resolution Letter is sent to Member within 15 days. Step 2: If Member is dissatisfied, Member can re-file grievance within 10 calendar days for review by Grievance Committee. Review transpires within 7 days of receipt with Meridian arranging for Member or authorized representative to attend meeting. Step 3: Resolution letter is sent to Member within 3 business days of Committee meeting.	Step 1: Member contacts NHHF to file Grievance. Go to step 2. Step 2: NHHF will provide an oral or written response within 45 calendar days of the member's grievance.	Step 1: Grievance information is forwarded to WS Appeals & Grievance Department Specialist to follow-up with member and sends Grievance Acknowledgement Letter within 1 day. Step 2: Decision made within 30 calendar days followed by a Grievance Resolution Letter.
Member wants to file an Appeal. **Appeal** - ability of Member (or provider on behalf of a Member) to request MCO review of a denied, reduced, or terminated service.	Step 1: Member calls to file an Appeal. However, Appeals Coordinator cannot review request until a written and signed appeal request form is submitted. Step 2: Appeal decisions are made within 30 calendar days from the date the appeal was filed. Step 3: If member is dissatisfied, member has the right to request a Fair Hearing with the State of New Hampshire within 30 days of the final appeal denial letter.	Step 1: Member contacts NHHF to file an Appeal. Step 2: NHHF provides a written decision within 30 calendar days from the date of the request. Step 3: If member is dissatisfied, member has the right to request a Fair Hearing with the State of New Hampshire within 30 days of the final appeal denial letter.	Step 1: Member or AR contacts WS to file an Appeal. Step 2: WS Standard Appeal decisions are made within 30 calendar days of request. Expedited Appeal decisions are made within 72 hours, both followed by Appeal Decision letter and State Fair Hearing rights. Step 3: If member is dissatisfied, member has the right to request a Fair Hearing with the State of New Hampshire within 30 days of the final appeal denial letter.

PROVIDER ISSUE ESCALATION

	Meridian	NH Healthy Families	Well Sense
Provider needs to resolve an issue.	Step 1: Provider contacts Provider Services to discuss the issue by telephone, email, or Provider Portal. Step 2: Provider Services or NH Provider Representative works within Meridian Departments to resolve issue.	Step 1: Provider contacts Provider Services to discuss issue by telephone, email, or Provider Portal. Step 2: Provider is connected with appropriate staff to resolve issue. Issues can include staff focused in Network Enrollment, Provider Inquiries, Behavioral Health, Pharmacy, Claims Payment, and Referral/Prior Authorization Management. Step 2: If issue is not resolved, in most instances it is escalated to a supervisor. Step 3: If issue is not resolved by a supervisor, it is escalated to a Director or Provider Relations representative.	Step 1: Provider may contact the assigned Provider Relations Consultant (PRC) or the Provider Services Call Center (PSCC). Step 2: PRC, within 1 day, attempts resolution with the provider. If not, PRC outreach to Vendor Services Manager or WS dept. associated with issue. Step 3: PRC communicates resolution to provide.r NOTE: if PSCC is involved, the provider will be referred to appropriate vendor or WS department for resolution with eventual involvement by the PRC who will communicate resolutions reaching the Vendor Services Manager or WS Department. All providers have Administrative Appeal rights to challenge the Plan's denial of a claim.